Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	005086	A. BUILDING _____ B. WING _____	C 10/19/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAJOR HOSPITAL	**150 W WASHINGTON ST SHELBYVILLE, IN 46176**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS This visit was for one (1) State complaint survey. Complaint number: IN00084953 Substantiated; no deficiencies cited. Date of survey: 10/17/2011 Facility number: 005086 Surveyor: Deborah Franco, RN Public Health Nurse Surveyor Major Hospital is in compliance with 410 IAC 15-1.5-2, Infection control and 410 IAC 15-1.5-6, Nursing service, Hospital Licensure Rules. QA: claughlin 11/04/11	S 000		

Indiana State Department of Health

TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE